Local Governmental Agency:
Contract Number:
Period of Service:

NEW MEDI-CAL ADMINISTRATIVE ACTIVITIES
INVOICE for LOCAL GOVERNMENTAL AGENCIES

Program:
Claiming Unit:
Invoice #:

	COST CATEGORIES:	FORMULA alpha = line numeric = cost pool	CP#1 SPMP (Enter)	CP#2 Non-SPMP (Enter)	CP#3a Non-Claim. (Enter)	CP#3b (Formulas) Non-Claim. Bal. from Dir. Chg.	CP#4 (Formulas) DIRECT CHARGES ENHANCED	CP#5 (Formulas) DIRECT CHARGES NON-ENHANCED	CP #6 (Enter) Allocated Cost & Revenue
A	Salary	(Enter)				$0	$0	$0	
B	Benefits	(Enter)				$0	$0	$0	
C	SUBTOTAL	A+B	$0	$0	$0	$0	$0	$0	$0
D	Personal Service Contracts	(Enter)				$0	XXXXXX	$0	XXXXXXX
E	SUBTOTAL PERSONNEL	C+D	$0	$0	$0	$0	$0	$0	$0
F	Distribution %	E/(CP1...CP5)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	XXXXXXX
G	MAA Transportation	(From Direct Charges.)	XXXXXXXXX	XXXXXX	XXXXXX	$0	XXXXXX	$0	XXXXXXX
H	Other Costs	(Enter)				$0	XXXXXX	$0	
I	Costs to be Distributed	E6+H6	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXX	XXXXXXXXX	$0
J	Distribution of Costs	I6 x F	$0	$0	$0	$0	$0	$0	XXXXXXX
K	SUBTOTAL OTHER COSTS	G+H+J	$0	$0	$0	$0	$0	$0	XXXXXXX
L	Collapse CP#3b	E3b+K3b	XXXXXXXXX	XXXXXXXXX	$0	XXXXXXXXX	XXXXXX	XXXXXXXXX	XXXXXXX
M	TOTAL COSTS	E+K+L	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXX
N	% OF TOTAL COST	M/(CP1-CP5)	0.00%	0.00%	0.00%	XXXXXXXXX	0.00%	0.00%	XXXXXXX
	FUNDING SOURCE ADJUSTMENT:			ALL FORMULAS					
O	Funding Sources	From Funding Sources	$0	$0	$0	XXXXXXXXX	$0	$0	$0
P	Reallocated CP#6 Funding Sources	O6 X N	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXXX
Q	TOTAL FUNDING SOURCES	O + P	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXXX
R	Non-Claimable Services Cost: CP#3	M3	XXXXXXXX	XXXXXXXX	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
S	Non-Claimable Service Cost: CPs #1 & 2	M x (AL+AM+AN)/(AQ-AO-AP)	$0	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
T	Remaining Funding Sources CP#3	(Q-R)>$0	XXXXXXXX	XXXXXXXX	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
U	Distribution %	S1/(S1+S2);S2/(S1+S2)	0.00%	0.00%	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
V	Reallocated CP#3 Funding Sources	T3 x U	$0	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
W	Remaining Revenue	If M=$0 or V<S,Q;else,V+Q-S	$0	$0					
X	Revenue to Personnel Services	If E=0,0; else W * E/M	$0	$0					
XX	Revenue to Other Costs	If K=0,0; else W * K/M	$0	$0					
Y	Adjusted Personnel Services Cost	If (E-X)=0,0; else E-X	$0	$0					
YY	Adjusted Other Cost	If (K-XX)=0,0; else K-XX	$0	$0					
Z	TOTAL ADJUSTED COST	Y+YY	$0	$0	XXXXXXXX	XXXXXXXX	$0	$0	XXXXXXXX

	ACTIVITIES		(Enter) MEDI-CAL %	(Enter) ACTIVITY RESULTS PERCENTAGES SPMP	(Enter) NON-SPMP	INDICATE METHODOLOGY USED TO DETERMINE MEDI-CAL %
AA	Medi-Cal Outreach (A)	A	100.00%	0.00%	0.00%	
AB	Medi-Cal Outreach (B1)	B	0.00%	0.00%	0.00%	AC____ Other____
AC	Medi-Cal Outreach (B2)	B	0.00%	0.00%	0.00%	CWA
AD	Facilitating Medi-Cal Application	C	100.00%	0.00%	0.00%	
AE	Arranging for Transportation	D	0.00%	0.00%	0.00%	CWA___ AC___ Other___
AF	Contract Administration A	E	100.00%	0.00%	0.00%	
AG	Contract Administration B	E	0.00%	0.00%	0.00%	CWA___ AC___ Other___
AH	Program Planning & Policy Develop. (A)	F	100.00%	0.00%	0.00%	
AI	Program Planning & Policy Develop. (B)	F	0.00%	0.00%	0.00%	CWA___ AC___ Other___
AJ	MAA/TCM Coor./Claims Admin.	G	100.00%	0.00%	0.00%	
AK	MAA Implementation Training		100.00%	0.00%	0.00%	
AL	Other Programs/Activities		XXXXXXXXXX	0.00%	0.00%	CWA = County-wide Average
AM	Direct Patient Care		XXXXXXXXXX	0.00%	0.00%	AC = Actual Count
AN	Targeted Case Management			0.00%	0.00%	
AO	General Admin. Time		XXXXXXXXXX	0.00%	0.00%	
AP	Paid Time Off		XXXXXXXXXX	0.00%	0.00%	
AQ	TOTAL TIME		XXXXXXXXXX	0.00%	0.00%	

Revised 4/2002

Local Governmental Agency:
Contract Number:
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NEW MEDI-CAL ADMINISTRATIVE ACTIVITIES
INVOICE for LOCAL GOVERNMENTAL AGENCIES
$0

Program:
Claiming Unit:
Invoice #:

ALL FORMULAS

	ALLOCATE ADMINISTRATION & PAID TIME OFF & APPLY MEDI-CAL %	(Formula - Disc Column)	Medi-Cal %	SPMP	1 Apply MC% SPMP (50%)	11 SPMP (75%)	Non-SPMP	111 Apply MC% Non-SPMP
BA	Medi-Cal Outreach (A)	{AA/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BB	Medi-Cal Outreach (B1)	{AB/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BC	Medi-Cal Outreach (B2)	{AC/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BD	Facilitating Medi-Cal Application	{AD/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BE	Arranging for Transportation	{AE/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BF	Contract Administration A	{AF/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BG	Contract Administration B	{AG/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BH	Program Planning & Policy Development(A)(enhanced)	{AH/SUM(AA..AO)}xMC%	100.00%	0.00%	XXXX	0.00%	XXXX	XXXX
	Program Planning & Policy Development(A)(non-enhanced)	{AH/SUM(AA..AN)}xMC% (less enh)	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BI	Program Planning & Policy Development(B)(enhanced)	{AI/SUM(AA..AO)}xMC%	0.00%	0.00%	XXXX	0.00%	XXXX	XXXX
	Program Planning & Policy Development(B)(non-enhanced)	{AI/SUM(AA..AN)}xMC% (less enh)	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BJ	MAA/TCM Coor./Claims Admin.	{AJ/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BK	MAA Implementation Training	{AK/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BL	Other Programs/Activities	AL/SUM(AA..AN)	XXXXXXXXX	0.00%	XXXX	XXXX	0.00%	XXXX
BM	Direct Patient Care	AM/SUM(AA..AN)	XXXXXXXXX	0.00%	XXXX	XXXX	0.00%	0.00%
BN	Targeted Case Management	AN/SUM(AA..AN)	XXXXXXXXX	0.00%	XXXX	XXXX	0.00%	0.00%
BO	TOTAL			0.00%	0.00%	0.00%	0.00%	0.00%

ALL FORMULAS

	CLAIM CALCULATION:		SPMP	Non-SPMP	
CA	Federal Non-Enhanced Basis Cost Pool #1	Z x (BO1)+ YY x (BO11)	$0		
	Federal Non-Enhanced Basis Cost Pool #2	Z x (BO111)		$0	
CB	Federal Non-Enhanced Share	(CA1 or CA2) x 50%	$0	$0	
CC	Federal Enchanced Basis	Y1 x (BO11)	$0	XXXXXXXX	
CD	Federal Enchanced Share	CC1 x 75%	$0	XXXXXXXX	
CE	Direct Charge: Enhanced Federal Share	Z4 x 75%	$0	XXXXXXXXX	
CF	Direct Charge:Non-Enhanced Federal Share	Z5 x 50%	XXXXXXXXX	$0	
CG	FFP @ 50%	CB1+CB2+CF2		FFP @ 50%	$0
CH	FFP @ 75%	CD1 + CE1		FFP @ 75%	$0
CI	TOTAL FEDERAL SHARE	CG + CH	XXXXXXXX	XXXXXXXX	**$0**

Activity Percentages Determined by One Month Time Study Completed in _____(month/year)

For DHS Program use only

I certify that this claim and any adjustment(s) are in all respects, true, correc
supportable by available documentation, and in compliance with all
terms/conditions, laws and regulations governing its payment.
The final adjusted approved amount for this invoice is $_____.

Approved by:_____

Date_____

Print Name:_____

Print Title:_____

I certify under penalty of perjury that the information provided on the invoice is true and correct, based on actual expenditures for the period claimed, and that the funds/contributions have been expended, as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51, for allowable administrative activities and that these claime expenditures have not previously been nor will not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claim Act.

Typed name of signer

Signature

Date

Department of Health Services
714 P Street, Rm 1140
Sacramento, CA 95814

Title

INVOICE PREPARATION INFORMATION

Typed name of preparer

Classification

Telephone #

Revised 4/2002

INSERT ROWS AS NECESSARY ON THE ROW ABOVE EACH CATERGORICAL TOTAL - SET PRINT RANGES FOR HARD COPY READABILITY

NEW MEDI-CAL ADMINISTRATIVE ACTIVITIES
FUNDING (REVENUE) SOURCES WORKSHEET

Local Governmental Agency:
Contract Number:
Period of Service:

Program:
Claiming Unit:
Invoice #:

Medi-Cal Fees + Match (List)	Purpose	Not Offset Funds	CP#1 SPMP	CP#2 Non-SPMP	CP#3a & b Non-Claimable	CP#4 Direct-Enhanced	CP#5 Direct-Non-Enhanced	CP#6 Allocated	TOTAL (CPs 1 - 6)
		$0	XXXXXXXXXX	XXXXXXXXXX		$0	$0	$0	$0
		$0	XXXXXXXXXX	XXXXXXXXXX		$0	$0	$0	$0
Total Medi-Cal Fees + Match		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Federal Grants + Match (List)									
		$0	$0	$0		$0	$0	$0	$0
		$0	$0	$0		$0	$0	$0	$0
Total Federal Grants + Match		$0	$0	$0	$0	$0	$0	$0	$0
State General Fund (List)									
		$0	$0	$0	$0	$0	$0	$0	$0
		$0	$0	$0	$0	$0	$0	$0	$0
Total State General Fund		$0	$0	$0	$0	$0	$0	$0	$0
Medicare (List)									
		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Total Medicare		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Insurance (List)									
		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Total Insurance		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Fees (List)									
		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Total Fees		$0	XXXXXXXXXX	XXXXXXXXXX	$0	$0	$0	$0	$0
Other Revenue (List)									
			$0	$0	$0	$0	$0	$0	$0
		$0	$0	$0	$0	$0	$0	$0	$0
Total Other Revenue		$0	$0	$0	$0	$0	$0	$0	$0
TOTALS:		$0	$0	$0	$0	$0	$0	$0	$0

I certify that the revenue sources identified above represent accurate identifiable costs for the program/claiming entity and that the direct charges have been properly identified and allocated. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief, and that I have notice that this information is to be used for filing a claim with the Federal Government for federal funds, and the knowing misrepresentation constitutes violation of the Federal False Claims Act.

Does Revenue cover Costs? YES

Signature

Date

Type or Print Name of Signer

Revised 4/2002

NEW MEDI-CAL ADMINISTRATIVE ACTIVITIES

DIRECT CHARGES WORKSHEET

Local Governmental Agency:
Contract Number:
Period of Service:

Program:
Claiming Unit:
Invoice #:

SECTION 1 — **PPPD ENHANCED - COST POOL #4**

ENHANCED - COST POOL #4

(All other costs are entered as non-enhanced)

Description (from claiming plan)	Medi-Cal Factor	Staff Salaries	Apply MC % (Formula)	Staff Benefits	Apply MC % (Formula)	Personal Services Contracts	Apply MC %	MAA Transportation	Apply MC %	Other Costs	Apply MC %	Claimable Costs (Formula)	S & B net of MC % (Formula)
From P P P D (B) Wksheet	100.00%	$0	$0	$0	$0	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	$0	$0
TOTAL COST POOL #4	XXXXXXX	$0	$0	$0	$0	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	$0	$0

SECTION 2 — **PPPD NON - ENHANCED - COST POOL #5**

NON- ENHANCED - COST POOL #5

Description (from claiming plan)	Medi-Cal Factor	Staff Salaries	Apply MC % (Formula)	Staff Benefits	Apply MC % (Formula)	Personal Services Contracts	Apply MC %	MAA Transportation	Apply MC %	Other Costs	Apply MC %	Claimable Costs (Formula)	S & B net of MC % (Formula)
From P P P D (B) Wksheet - non-SPMPs	100.00%	$0	$0	$0	$0	XXXX	XXXX	XXXX	XXXX	$0	$0	$0	$0
From P P P D(B) Wksheet - SPMPs	100.00%	$0	$0	$0	$0	XXXX	XXXX	XXXX	XXXX	$0	$0	$0	$0
SUBTOTAL COST POOL #5	XXXXXXX	$0	$0	$0	$0	XXXX	XXXX	XXXX	XXXX	$0	$0	$0	$0

SECTION 3 — **NON - ENHANCED - COST POOL #5**

NON- ENHANCED - COST POOL #5

Description (from claiming plan)	Medi-Cal/Certified Time Factor %	Gross Staff Salaries	Apply MC %	Gross Staff Benefits	Apply MC %	Pers. Serv. Contracts	Apply MC %	MAA Transportation	Apply MC %	Other Costs	Apply MC %	Total Costs	Net of MC %	Balance Remaining to CP#3b
	(Enter)	(Enter)	(Formula)	(Enter)	(Formula)	(Enter)	(Formula)	(Enter)	(Formula)	(Enter)	(Formula)	(Formula)	(Formula)	(Formula)
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
SUBTOTAL Section 3	XXXXXXX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
SUBTOTAL Section 2	XXXXXXX	$0	$0	$0	$0	XXXX	XXXX	XXXX	XXXX	$0	$0	$0	$0	$0
TOTAL COST POOL #5	XXXXXXX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

SECTION 4

	Staff Salaries		Staff Benefits		Pers. Serv. Contracts		MAA Transportation		Other Costs				Remaining to CP#3b
TOTAL TO COST POOL # 3B	$0	XXXX	$0	XXXX	$0	XXXX	$0	XXXX	$0	XXXX	XXXX	XXXX	$0

I certify that the direct charges identified above represent accurate identifiable costs for the program/claiming entity and that the direct charges have been properly identified and allocated. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief, and that I have notice that this information is to be used for filing a claim with the Federal Government for federal funds, and the knowing misrepresentation constitutes violation of the Federal False Claims Act.

____
Signature

____
Date

____
Type or Print Name of Signer

Local Governmental Agency:
Contract Number:
Period of Service:

Program:
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PROGRAM PLANNING AND POLICY DEVELOPMENT (B) WORKSHEET

SPMP

		(Enter)	(Formula) %
DA	Salaries	$0	0.00%
DB	Benefits	$0	0.00%
DC	Total Salaries and Benefits	$0	0.00%
DD	Other Costs	$0	
DE	TOTAL COST	$0	

NON-SPMP

		(Enter)	(Formula) %
EA	Salaries	$0	0.00%
EB	Benefits	$0	0.00%
EC	Total Salaries and Benefits	$0	0.00%
ED	Other Costs	$0	
EE	TOTAL COST	$0	

SPMP FORMULAS

PROGRAM TYPE SPMP		(Enter) Medi-Cal %	(Enter) Time Units*	Time %	Salary & Benefi Cost	Other Cost	Reallocate PTO %	Distribute PTO $ - S & B	Distribute PTO $-other	Distribute Admin. %	Admin. to S & B $	Admin. to Other $	Total Program Cost S & B	Total Program Cost Other	Cost Pool #5 Apply Medi-Cal % to Admin	Cost Pool #5 Apply Medi-Cal % to Other	Cost Pool #4 Apply Medi-Cal % to Program	Cost Pool #3b S & B	Cost Pool #3b Other	TOTAL
DF	Medi-Cal Services for Medi-Cal Clients Only	100.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DG	Medi-Cal Services (general population) CWA	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DH	Non Medi-Cal Program	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DI	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DJ	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DK	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DL	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DM	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DN	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DO	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DP	General Administration	XXXX	0.00	0.00%	$0	$0	0.00%	$0	$0	XXXX	XXXX		XXXX		XXXX		XXXX	XXXX		XXXX
DQ	Paid Time Off	XXXX	0.00	0.00%	$0	$0	XXXX	XXXX	XXXX	XXXX	XXXX		XXXX		XXXX		XXXX	XXXX		XXXX
DR	SPMP Total	XXXX	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DS	SPMP Salaries (DA% x DR)	XXXX	XXXX	XXXX	XXXX		XXXX	XXXX		XXXX	XXXX		XXXX		$0		$0	$0		XXXX
DT	SPMP Benefits (DB% x DR)	XXXX	XXXX	XXXX	XXXX		XXXX	XXXX		XXXX	XXXX		XXXX		$0		$0	$0		XXXX

NON-SPMP FORMULAS

PROGRAM TYPE NON-SPMP		(Enter) Medi-Cal %	(Enter) Time Units*	Time %	100% Cost	Other Cost	Reallocate PTO %	Distribute PTO $ - S & B	Distribute PTO $-other	Distribute Admin. %	Admin. to S & B $	Admin. to Other $	Total Program Cost S & B	Total Program Cost Other	Cost Pool #5 Apply Medi-Cal % to Program	Cost Pool #5 Apply Medi-Cal % to Other	Cost Pool #4 Apply Medi-Cal % to Program	Cost Pool #3b S & B	Cost Pool #3b Other	TOTAL
EF	Medi-Cal Services for Medi-Cal Clients Only	100.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EG	Medi-Cal Services (general population) CWA	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EH	Non Medi-Cal Program	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EI	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EJ	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EK	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EL	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EM	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EN	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EO	Medi-Cal Program w/identified MC%	0.00%	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
EP	General Administration	XXXX	0.00	0.00%	$0	$0	0.00%	$0	$0	XXXX	XXXX		XXXX		XXXX		XXXX	XXXX		XXXX
EQ	Paid Time Off	XXXX	0.00	0.00%	$0	$0	XXXX	XXXX		XXXX	XXXX		XXXX		XXXX		XXXX	XXXX		XXXX
ER	NON-SPMP Total	XXXX	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	XXXX	$0	$0	$0
ES	**TOTAL (SPMP+nonSPMP)** (DR+ER)	XXXX	0.00	0.00%	$0	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ET	Non-SPMP Salaries (EA% x EP)	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	$0	XXXX	XXXX	$0	XXXX	XXXX
EU	Non-SPMP Benefits (EB% x EP)	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	$0	XXXX	XXXX	$0	XXXX	XXXX

*Unit of time used: _____